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Twelve Defining Moments in the History of Alcoholics Anonymous

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Abstract

Misconceptions about Alcoholics Anonymous (AA) abound in spite of (or because of) the thousands of theses, dissertations, books, professional and popular articles, and Internet commentaries that have been written about AA. One of the most pervasive characterizations of AA is that it is a "treatment" for alcoholism—a characterization that distorts the meaning of both mutual aid and alcoholism treatment. This article describes 12 character defining moments in the history of AA that highlight the differences between AA and alcoholism treatment.

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Introduction

There is a long history of recovery mutual aid groups that pre-date the founding of Alcoholics Anonymous—Native American recovery "circles"; the Washingtonians; Fraternal Temperance Societies; Ribbon Reform Clubs; institutional support groups such as the Ollapod Club, the Godwin Association, and the Keeley Leagues; and early faith-based recovery fellowships such as the Drunkards Club and the United Order of Ex-Boozers (White, 2001). There is a similarly rich history of modern adaptations and alternatives to Alcoholics Anonymous that include an ever-growing list of Twelve Step fellowships, as well as explicitly religious (e.g., Alcoholics Victorious, Overcomers Outreach, Liontamers Anonymous, Celebrate Recovery and Ladies Victorious) and secular (e.g., Women for Sobriety, Moderation Management, Secular Organizations for Sobriety, Rational Recovery, LifeRing Secular Recovery) frameworks for addiction recovery (Kurtz & Kurtz, 2007).

Alcoholics Anonymous (AA) has earned its place as the benchmark by which all other mutual aid groups are compared (Kurtz & White, 2003). That distinction is the product of AA's:

- Historical survival and longevity (White, 1998)
- Growth (nearly 2 million members and more than 106,000 local groups)(Alcoholics Anonymous, 2007)
- Geographical dispersion and accessibility (150 countries)(Alcoholics Anonymous, 2007)
- Role in inspiring larger social reform movements (Johnson, 1973; Roizen, 1991)
- Influence on the modern treatment of alcoholism and other drug dependencies (White, 1998), and its
- Influence on the popular culture (Room, 1989, 1993).

Because of its emergence as an enduring, international movement, AA has been subjected to a level of scrutiny beyond that of any of its predecessors or current rivals. In 1994, Pittman and Bishop published a bibliography of AA literature that listed more than 2,900 books, dissertations, theses and articles written on AA. Such attention, particularly scientific attention, has since increased, as has the literature of an AA backlash movement whose books/articles have spawned their own mini-industry (See the writings of Peele, Bufe, Ragge and Trimpey as illustrative examples) and Internet websites (e.g., http://www.orange-papers.org/orange-not_good.html, http://www.aadeprogramming.org/index_frames.html). Often responding to such

public criticisms of AA are recently sobered and grateful alcoholics--the least qualified persons to speak about what AA is and is not, for given the value that AA places on humility and tolerance and its traditions of anonymity and non-involvement in outside issues, the AA member who is the first to step into the limelight to defend AA is by definition the least qualified to do so.

The ever-growing definitions of AA have reached a point where they tell us more about each author than about AA as an organization or a framework of alcoholism recovery (Miller & Kurtz, 1994). AA has been variably depicted as a society (Wilson, 1949), social movement (Room, 1993), culture of recovery (White, 1996), system of beliefs and speech event (Makela, et al, 1996); spiritual program (Miller & Kurtz, 1994), and a religious cult (Bufe, 1991). One of the most pervasive characterizations of AA is that of a "treatment" for alcoholism (Bebbington, 1976; Tournier, 1979; Emrick, 1989; Najavits, Crits-Christoph, & Dierberger, 2000; McGovern & Carroll, 2003).

In 1994, psychologist William Miller and AA historian Ernest Kurtz, wrote a seminal article noting popular and professional misconceptions about AA. Using AA's own literature, Miller and Kurtz challenged these misconceptions.

> *AA writings do not assert that: (1) there is only one form of alcoholism or alcohol problems; (2) moderate drinking is impossible for everyone with alcohol problems; (3) alcoholics should be labeled, confronted aggressively or coerced into treatment; (4) alcoholics are riddled with denial and other defense mechanisms; (5) alcoholism is a purely physical disorder; (6) alcoholism is hereditary; (7) there is only one way to recover; or (8) alcoholics are not responsible for their condition or their actions* (Miller & Kurtz, 1994, p. 165)

This chapter extends the work of Miller and Kurtz by using AA's own history to elucidate the essential character of AA. That historical evidence confirms that AA is not a treatment for alcoholism and that such a characterization distorts the nature of and diminishes the potential value of both AA and alcoholism treatment.

There are moments in the lives of individuals, families, organizations and countries that can profoundly and permanently shape character and identity. Each of the following seminal events in the history of Alcoholics Anonymous offers a window of insight into those dimensions of character that separate AA from other recovery mutual aid groups and from professionally directed alcoholism treatment. Unless otherwise noted, the historical incidents described are drawn from four AA publications which will be subsequently referenced using their acronyms, *Alcoholics Anonymous Comes of Age (AACA), 'Pass It On': The Story of Bill*

Wilson and How the AA Message Reached the World (PIO), Dr. Bob and the Good Oldtimers (DBGO) and *Twelve Steps and Twelve Traditions* (TSTT), and Ernest Kurtz's scholarly study, *Not-God: A History of Alcoholics Anonymous*.

1. Jung's Refusal

In 1926, Rowland Hazard, a Yale graduate and prominent Rhode Island businessman, was treated for alcoholism by the renowned psychoanalyst Carl Jung (Bluhm, 2006). Following a relapse in 1927, Hazard requested further treatment from Jung. Jung refused this request on the grounds that Hazard had received the best of what psychiatric and medical science had to offer and that hope for future recovery would have to be found elsewhere. In this communication with Hazard, Jung added that the rabid appetite for alcohol had been quelled in some alcoholics through the medium of a powerful spiritual or religious experience. He suggested Hazard seek such an experience. That recommendation led to Hazard's subsequent involvement with the Christian evangelical Oxford Group. Sobered within the Oxford Group, Rowland Hazard began carrying his message of hope to other alcoholics. In November1934, Hazard carried such a message of hope to Ebby Thacher. On the verge of being sentenced to Windsor Prison, Thacher was instead released to Hazard's custody. In late November 1934, the newly sobered Thacher carried that same message of hope to his long-time friend Bill Wilson. Thacher's visits created no instantaneous conversion, but they did start a new "internal dialogue" that triggered a crisis in Wilson's drinking and served as a catalyst for the subsequent events that marked the founding of Alcoholics Anonymous (PIO, 1984, p. 115).

The Jung-Hazard-Thacher-Wilson chain of interactions mark the earliest catalytic moments in the founding of Alcoholics Anonymous. Jung brought an affirmation of the limitations of professional assistance in recovery from alcoholism, and he added professional legitimacy to the transformative power of spiritual experience. The Hazard-Thacher-Wilson connections established the "kinship of common suffering" (one alcoholic sharing with another alcoholic) as the basic unit of interaction in the yet-to-be-born organization of AA (AACA, p. 59). Sociologist Frank Riesman (1965, 1990) later described the potential catalytic, self-healing effects of helping others as the "helper principle."

The legitimacy of the helper in the Hazard-Thacher and Thacher-Wilson relationships came not from the kind of external authority that Jung and other service professionals possessed, but from "experiential knowledge" and "experiential expertise" (Borkman, 1976). Credential verification came not from a university registrar's office, but through a presentation and acceptance of one's own life story. Stanley Jackson (2001) recently noted of this "wounded healer"

tradition: "They have established their credentials as persons who know first-hand about suffering, who have suffered and emerged from the experience stronger and wiser, and who have the capacity to serve others as healers of souls" (p. 6). The Hazard-Thacher-Wilson relationships were built on a foundation of moral equality, emotional authenticity and a profound level of mutual empathy and identification.

The Hazard-Thacher-Wilson chain also offers the first evidence we have of the coming importance of story construction and storytelling in AA. AA's unique storytelling style was described as follows in 1939, "Our stories disclose in a general way what we used to be like, what happened, and what we are like now" (Alcoholics Anonymous, 1939, p. 70). What one offers in interactions within AA is not "feedback," "counseling," "treatment" or even "advice", but one's own "experience, strength and hope" couched in the form of story. Within AA, this distinctive style of interaction evolved into what Borkman (1999) has described as the "sharing circle"—an egalitarian exchange of life stories detailing the experiences of alcoholism and alcoholism recovery. Such storytelling was institutionalized as a form of spiritual communion within the fellowship of AA.

As people in recovery assumed paid roles as alcoholism counselors and as this role became progressively professionalized, self-disclosure of their recovery status and their recovery stories became viewed as "unprofessional" and a sign of "poor boundary management" (White and Popovits, 2001). The differences in the relationship between counselor and the client in alcoholism treatment and the relationship between AA member and AA member, as well as the sponsor and sponsee relationship, was further widened when AA promulgated guidelines for AA members working in the alcoholism field (A.A. Guidelines…, ND). The attributes identified in these Guidelines that were seen as essential for working professionally in the alcoholism field were defined, not in terms of technical skill, but in terms of the ability to maintain clear role separation and in terms of such traits as faith, courage, self-discipline, humility, patience and tolerance.

2. A "Hot Flash" and Failed Evangelism

Following Ebby Thacher's visits, Bill Wilson's drinking reached another point of crisis and on December 11, 1934 he was re-hospitalized for detoxification at the Charles B. Towns Hospital in New York City. At age 39 and unbeknownst to him, Bill Wilson had taken the last drink of his life. A few days into this belladonna-facilitated detoxification, Wilson, a confirmed agnostic, underwent a profound spiritual experience in the aftermath of a deepening depression:

> *The last vestige of my proud obstinacy was crushed. All at once I found myself crying out, "If there is a God, let Him Show Himself! I am ready to*

> *do anything, anything!" Suddenly the room lit up with a great white light. I was caught up into an ecstasy which there are no words to describe.... And then it burst upon me that I was a free man.....All about me there was a wonderful feeling of Presence, and I thought to myself, "So this is the God of the Preachers!" (Alcoholics Anonymous, 1957).*

Later questioning whether he was losing his sanity, Wilson described the experience to his physician, Dr. William Silkworth. Silkworth, known in AA folklore as "the little doctor who loved drunks," framed the event as a potential conversion experience.

> *No. Bill, you are not hallucinating. Whatever you got, you had better hang on to; it is so much better than what you had only an hour ago. (AACA, 1957, p. 13)*

What easily could have been understood as an organic psychosis or a toxic side effect of medication was instead interpreted by Silkworth as a potentially life-transforming spiritual experience.

Bill Wilson's "Hot Flash" as it came to be known within AA—drawn from a popular phrase used in the mid-twentieth century to convey a sudden idea of great value or a life-changing event or experience--is important in several ways in the larger story of AA. It further validated that medical care for alcoholism was necessary but in itself insufficient (a fact confirmed by Wilson's prior hospitalizations), and that spiritual experience could open a pathway to long-term recovery. Wilson's experience at Towns' Hospital established early in AA history the potential for what psychologists today describe as "quantum" or "transformational" change—a sobering personal transformation in identity and character that is unplanned, vivid, positive and permanent (Miller & C'de Baca, 2001; White, 2004). Dr. Silkworth's response to Wilson's transformational change experience also underscored the limits of medical/psychiatric treatment and, like Jung's earlier response, set a precedent for professional humility and respect for the potential role of spirituality in alcoholism recovery.

In the months following his discharge, Bill Wilson tried to sober up the world, but the drunks at the Towns Hospital and Calvary mission to whom he described his Hot Flash were uniformly unimpressed and unmoved. Wilson eventually discovered that others would achieve successful recovery through a quite different process. This imbedded the idea of the varieties of recovery experience within AA's earliest history and led Wilson to later affirm that "the roads to recovery are many" (Wilson, 1944). The distinctions between and

legitimacy of a climactic "spiritual experience" and a slower process of "spiritual awakening" were judged to be important enough to later discuss in a special appendix of the book *Alcoholics Anonymous*.

Bill Wilson himself soon discovered on a visit to Akron, Ohio that undergoing a profound spiritual experience does not automatically silence the siren call of the bottle.

3. Panic at the Mayflower Hotel

In May 1935, Bill Wilson, demoralized at the end of a failed business trip, found himself in the lobby of the Mayflower Hotel fearing that he might take a drink and destroy his hard-earned sobriety. His sense of what he needed to prevent his return to drinking was not to reach out to a professional, but to find another alcoholic with whom he could talk. A series of phone calls led him to Dr. Robert Holbrook Smith who was at that time struggling with his own alcoholism. Their growing friendship, mutual support and vision of helping other alcoholics marked the formal ignition of AA as a social movement. The date of Dr. Bob Smith's last drink in June of 1935 is celebrated as AA's founding date.[1] Soon after that last drink, Bill Wilson and Dr. Bob Smith began the search for AA number three.

The mutual discovery that Bill Wilson and Dr. Bob Smith could achieve together what they had failed to achieve alone became the glue that held AA together. The discovery that the gift of sobriety could only be retained by giving it to others rose to consciousness in these earliest days of AA. The call from the Mayflower Hotel was the first incident in AA history in which an alcoholic picked up a telephone rather than a drink, affirming the potential of replacing dependence upon a drug with interdependence between members of a recovering community. This event also set the basic relationship within AA as one in which no member could claim moral superiority over another.

There are several aspects of this early encounter that distinguish it from other relationships intended to help the alcoholic. Facing the most severe test of his early sobriety, Wilson sensed that he needed, not professional counseling, but the communion that comes from shared experience and mutual vulnerability. The Wilson-Smith relationship was voluntary as opposed to coerced, reciprocal (service to others as service to self) as opposed to fiduciary (one party having obligation to care for the other), sustained as opposed to transient, personal as opposed to paid, and free of even a whisper of contempt. An event in New York soon threatened the future of these critical characteristics.

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[1] That date has been celebrated on June 10, but recent historical research suggests the date of Dr. Bob Smith's last drink was probably June 17, 1935 (White & Merton M., 2006).

4. Professionalism: AA's First Temptation

By late 1936, fledgling groups of recovered alcoholics were meeting within the larger framework of the Oxford Group in Akron, Ohio and the New York City area. Bill Wilson was staying sober and laboring full time to spread what would become the AA movement, but a crisis was brewing in terms of the poverty in which he and his wife Lois were living. It was in this circumstance that Charles B. Towns, owner of the Towns Hospital where Wilson had repeatedly been treated and whose corridors he now roamed trolling for drunks who might be interested in his nascent program, offered Wilson paid employment at the hospital as a "lay alcoholism therapist." Wilson's first instinct was that this was the perfect solution to his financial straits and his desire to work full time to spread this new message of hope to alcoholics. There was after all a precedent for this lay alcoholism psychotherapy role. Towns' offer to Bill Wilson was preceded by a tradition of distinguished lay therapists in the alcoholism arena that included Courtenay Baylor, Francis Chambers, and, most importantly, Richard Peabody whose book, *The Common Sense of Drinking*, was currently popular. Bill Wilson could have easily become part of this growing network of lay therapists.

The response of his fellow recovering alcoholics to Bill Wilson's employment opportunity marked one of the first examples of what would come to be called "group conscience" in Alcoholics Anonymous. The group rejected the idea on the grounds that their emerging fellowship could be hurt by tying itself to a hospital and that Bill's accepting a paid position could destroy this fledgling community of recovered alcoholics. "Why should we do for nothing what you'd be getting paid for? We'd all be drunk in no time"(PIO, 1984, p. 177). Eventually convinced of the wisdom of what he was hearing, Wilson turned down the Towns' offer. In that act, even before the young fellowship had found its own name, Alcoholics Anonymous escaped its first temptations: professionalism and the potential use of AA by an AA member for personal financial gain. By defining itself as a spiritual program, the fellowship declared that its most essential elements were not for sale. In retrospect, one can only speculate on what might have happened had Bill Wilson accepted the proffered patronage of Charles Towns and his hospital.

By the end of 1937, the fellowship had 40 sober members. At this point, one man seeking entrance tested its character and indeed its very soul.

5. Who can be an AA member?

In 1937, a man approached the numerically larger Akron group to inquire about possible membership. He ended his appeal with the following words,

> *But will you let me join your group? Since I am the victim of another addiction even worse stigmatized than alcoholism, you may not want me among you. Or will you?*
> (TSTT, 1981, p. 142).

The question of inclusion was not whether this man was an alcoholic. It was that he was homosexual. In the social climate of the late 1930s, this question set the group conscience of to boiling. Initial concerns were raised about how this could bring disgrace to the fellowship and keep some people from seeking its help. There was precedent for such exclusion. Some nineteenth century recovery mutual aid societies developed membership criteria that excluded all but "reputable drunkards" (White, 1998). An emerging AA was on the verge of just such a decision. Bill Wilson later explained how the deadlock was broken.

> *And finally the day of resolution came. A bunch of us were sitting in Dr. Bob's living room, arguing. What to do? Where upon dear old Bob looked around, and blandly said, 'Isn't it time folks to ask ourselves, "What would the Master do in a situation like this?" Would he turn this man away? And that was the beginning of the AA tradition that any man who has a drinking problem is a member of AA if he says so, not whether we say so*.
> (Borden, 2007, p. 18).

When AA experienced rapid growth in early 1940s and before the Twelve Traditions had been created to govern its organizational life, it was not unusual for local groups to develop all manner of membership criteria and even to blackball some seeking membership (White, 1998; Wally P., 1995).

> *So beggars, tramps, asylum inmates, prisoners, queers, plain crackpots, and fallen women were definitely out. Yes sir, we'd cater only to pure and respectable alcoholics! Any others would surely destroy us….We built a fine mesh fence around A.A.* (TSATD, 1952, p. 140).

As groups began to communicate with each other, it became clear that, "If all those rules had been in effect everywhere, nobody could have possibly joined AA…" (TSTT, 1952, p. 140). The 1937 Akron principle prevailed and was later codified in AA's Third Tradition. The phrase "honest desire to stop drinking" in the original 1939 statement of AA's singular membership requirement was simplified in 1949 to "desire to stop drinking" to assure inclusiveness.

This milestone marks an important contrast between AA and alcoholism treatment organizations. Where the latter would evolve elaborate admission criteria that served as exclusion as well as inclusion criteria and the practice of administratively discharging clients who lacked sufficient motivation or drank

following their admission, AA's threshold of engagement was simple but non-negotiable. No one within or outside AA had the authority to bar entrance to AA or throw someone out of AA as long as a single criteria was present: a desire to stop drinking.

6. A Rich Man's Warning about Money

Bill Wilson's decision not to accept the offer of employment at Towns Hospital did not quell his larger vision of AA missionaries and AA hospitals—a vision that continued to propel his search for philanthropic funds to support a growing AA. The quest for financial support led in February 1938 to a meeting with the staff of John D. Rockefeller, Jr. Rockefeller was widely known for his philanthropy and his support for other projects that had sought to address alcohol-related problems. After reviewing AA's past work and future plans and the recommendation of his staff to provide $50,000 in funding to AA, Rockefeller expressed his fear that money might harm this quite remarkable movement (Kurtz, 1991). Rockefeller's hesitance was his concern that material assets could corrupt the spiritual nature of the rising AA movement.

Rather than provide the requested $50,000, Rockefeller placed $5,000 in the treasury of Riverside Church to provide temporary financial support for Dr. Bob Smith and Bill Wilson. Today, one could only speculate how receipt of $50,000 in 1938 (the equivalent of over $600,000 today http://www.westegg.com/inflation) would have shaped the subsequent organization and core values of AA as well as its historical fate. AA might have easily morphed into just one more service agency if such funding would have necessitated a board of directors, a paid director, a paid service staff, the inimitable policy and procedures manuals and financial/service reporting systems and future licensing and accreditation processes. AA co-founders later reflected that Rockefeller's refusal had saved them from themselves. The fellowship's pledge of corporate poverty is in marked contrast to a multi-billion dollar addiction treatment industry and the pressure addiction treatment organizations experience to maintain and increase their revenues.

7. The Split from the Oxford Group

Between 1935 and 1937, the growing number of sobered alcoholics (the "alcoholic squadron") that constituted AA's first generation continued to meet within the larger framework of the Oxford Group (OG), but there was strain in the relationship between alcoholic and non-alcoholic OG members, particularly in New York City. Bill Wilson was criticized for his pre-occupation with alcoholics, and alcoholics at the OG-affiliated Calvary Mission were discouraged from

attending meetings at Bill Wilson's Clinton Street home. Wilson would later say of this tension, "The Oxford group wanted to save the world, and I only wanted to save drunks" (Kurtz, 1991, p. 44). Differences in their central missions, core beliefs and meeting rituals eventually led to a split between the OG and AA. That split occurred in New York in 1937 and in Ohio in 1939, but a distinct AA identity did not gel until 1939. The first meeting independent of the OG that called itself Alcoholics Anonymous occurred in Cleveland on May 18, 1939.

The departure from the OG was another critical milestone in AA history for several reasons. First, the split affirmed that whatever this new group was, it was not a religion, nor did it have any religious affiliation: "We are not allied with any particular faith, sect or denomination, nor do we oppose anyone." (Alcoholics Anonymous, 1939, p. viii). This transition opened the doors of entry to AA to future generations of alcoholics of multiple faiths and of no faith. Second, in breaking with the OG, AA emancipated spirituality from its religious roots in a manner later self-characterized as "spiritual but not religious." AA forged what it was, in part by figuring out, via group conscience, what it was not.

The centrality of spirituality is a distinct feature of AA. Alcoholism treatment institutions and practitioners may talk about the role of spirituality in alcoholism recovery, but few would claim that spirituality is the core of their approach to treatment. AA unashamedly claims just that. That stance separated AA from alcoholism treatment and from later explicitly religious and explicitly secular recovery mutual aid societies.

8. "Here are the steps we took…"

Plans for a book describing their program of recovery proceeded in tandem with the growth of sober members. As AA separated from the OG, its members articulated six principles adapted from the OG that had guided their recoveries:

1. We admitted that we were licked, that we were powerless over alcohol.

2. We made a moral inventory of our defects or sins.

3. We confessed or shared our shortcomings with another person in confidence.

4. We made restitution to all those we had harmed by our drinking.

5. We tried to help other alcoholics, with no thought of reward in money or prestige.

*6. We prayed to whatever God we thought there was for power to practice these precepts.. (*AACA, 1957, p. 160)

In December 1938, Bill Wilson expanded these six principles to twelve steps that reflected the experience of AA's earliest members. These steps were included in the crucial fifth chapter of what came to be known as AA's "Big Book." Refinements resulting from group discussions were made in the wording of the steps and a prologue was later added that stated, "Here are the steps we took, which are suggested as a program of recovery" (Alcoholics Anonymous, 1939, p. 71)

The codification of the AA program in book form was a central vehicle for the diffusion of AA and the crucial means of maintaining the integrity of the AA program as Alcoholics Anonymous experienced explosive growth in the years following the book's publication. The decision that the fellowship would publish its own materials also heightened its organizational autonomy and generated a substantial portion of the income that would support its central service structures. A critical examination of AA's Twelve Steps further underscores the differences between AA and the professional treatment of alcoholism.

Professional treatments for alcoholism purport to be theory-grounded, science-based, professionally delivered and supervised, and externally accountable (to a variety of regulatory and funding bodies). AA's Steps and the larger body of literature in which they are imbedded have little to say about alcoholism, its etiological roots or its treatment. The steps and all other AA literature focus instead on the experience of the alcoholic. What statements that can be found on the etiology of alcoholism and on alcoholism recovery depict alcoholism as a malady of spirit and character (e.g. "self-centeredness"; "self-will run riot") and its resolution as a spiritual rather than medical or psychological process (Kurtz, 2002). Alcoholics Anonymous makes no claim to scientific truth; it claims only the lessons of collective experience. AA's Steps are not intervention protocol performed by and supervised by professionals, but actions taken by members who are achieving the goals of sobriety and serenity. The "we" and "our" in AA's steps refer not to a relationship between a therapist and a client, but relationships within a community of recovering people. Where the centerpiece of treatment is made up of clinical protocol and the professionals who deliver it, the centerpiece of AA is the shared experiences of and interpersonal relationships between its members as they seek resources within and beyond themselves to quell the appetite for alcohol.

AA's steps focus not on treatment offered by others, but on the actions taken by alcoholics that have resulted in successful recoveries. Treatment, in the alcoholism context, is what a professional administers to an alcoholic. Recovery, in this same context, is what the alcoholic experiences on his or her way to health and wholeness. The relational context of the Steps is not one of professional therapy, but one of mutual support. The actions suggested in the Steps are ones

taken not in the context of professional treatment, but in the context of membership in a community of shared experience.

9. Growing Pains

The speedy decline of the Washingtonians following their rapid growth to more than 400,000 members in the early 1840s confirmed the dangers posed by the sudden growth of recovery mutual aid societies (White, 1998). Alcoholics Anonymous experienced both local and national surges in membership in the 1940s. This growth was generated in great part by early media coverage: a September 1939 article on AA in *Liberty Magazine*, a series of *Cleveland Plain Dealer* (in October and November) of that same year, and newspaper sports page coverage of the spring 1940 announcement that the Cleveland Indians star catcher had joined AA. This early visibility was followed by a *Saturday Evening Post* article in March 1941 that led AA's membership to grow from 2000 members to 8000 members in that year alone. AA learned several lessons during this first period of dramatic growth.

The calls coming into AA in Cleveland were so great that members with minimal sobriety time were asked to make Twelve Step calls. When both the newly sobered and their new recruits stayed sober, Alcoholics Anonymous learned that its message could be conveyed by very imperfect messengers. AA also learned that it could grow by expansion or by at times a more conflictual cell division. The inevitable personality tensions that emerged during the rapid induction of new members spawned new meetings and triggered the adage, "The only things required to start a new AA meeting are a resentment and a coffee pot."

Early AA members found creative ways to reach alcoholics in communities that did not yet have local meetings. Letter writing and visits by AA members who traveled as part of their jobs were particularly relied upon to reach those in need. The dissemination of the book, *Alcoholics Anonymous*, played a pivotal role in spreading AA's message. A unique approach to inducting new members (sponsorship) also emerged in Cleveland and was rapidly diffused throughout AA. By 1944, Alcoholics Anonymous had learned that as an organization it could survive rapid growth and in the process began to see itself as a movement that could spread throughout America and beyond. AA's self-awareness as a growing social movement heightened the difference between AA and professional treatment, but the question remained whether AA would need a paid professional class and special institutions to support this growing movement.

10. AA and the Business of Alcoholism Treatment

Alcoholics Anonymous faced a critical challenge in the late 1930s and early 1940s. Most alcoholics reaching out to it were in late stages of alcoholism. Alcoholics in such a state could and did die from alcohol withdrawal. Yet helping professionals generally eschewed work with alcoholics, and many hospitals had morality clauses that refused admission to alcoholics. These were the conditions that contributed to Bill Wilson's early vision of AA missionaries and AA hospitals. Rockefeller's refusal to provide $50,000 to AA tempered but did not eliminate this vision. AA members who were part of the medical profession (e.g., Dr. Bob Smith in Akron and Teddy R. in New York City) had helped open alcoholism treatment units in local hospitals, and AA committees were organizing alcoholism services in what has been described as the *Knickerbocker Paradox*. At the Knickerbocker Hospital in New York City, AA members remodeled a newly opened alcoholism unit. AA members had admitting privileges and visited patients daily in the unit. Patients were only discharged to AA sponsors. And yet local AA declared that AA had no official role in Knickerbocker's alcoholism treatment unit—developing a clear distinction between what was done by AA as an institution and what was done by AA members either individually or collectively (White, 1998).

The closest AA itself came to owning and operating a hospital for the treatment of alcoholism was in Cleveland in the early 1940s. Several occurrences moved AA members to abort this effort, including the sudden illness of the individual raising funds for the project, but in the end it was the AA's group conscience that ended the vision of paid AA missionaries and AA hospitals. After the collapse of the Cleveland project, AA's position on such outside projects hardened. As one AA trustee declared, "Better do one thing supremely well than two things badly" (Quoted in White, 1998, p. 164). This position was soon expanded:

> *Neither A.A. as a whole nor any A.A. Group ought to enter any other activity than straight A.A. As groups, we cannot endorse, finance or form an alliance with any other cause, however good…. But, if these projects are constructive and non-controversial in character, A.A. members are free to engage in them without criticism if they act as individuals only, and are careful of the A.A. name (Dangers in Linking A.A.…, 1947).*

What emerged within AA was an understanding that Alcoholics Anonymous was not a treatment for alcoholism and that treatment for alcoholism was an outside endeavor to which AA should not be formally linked. The view of the distinction between AA and treatment became most clear in a crisis at High Watch Farm.

As noted earlier, many AA members acting as individuals helped establish hospital-based alcoholism treatment units and volunteered or were employed in such units. AA members were also involved in non-hospital settings that provided post-detoxification rehabilitation—places referred to as "AA farms" or "AA retreats" until AA objected to such designation. High Watch Farm was a retreat in Kent, Connecticut where, beginning in 1940, AA members could initiate or strengthen their recovery from alcoholism. A small board of AA members, including Bill Wilson and Marty Mann, oversaw the management of High Watch. Daily operations were directed by Ray C., who provided a structured program of lectures, assigned reading, meditation and AA meetings. But Ray C. was a psychologist and the spiritually-grounded philosophy of the High Watch soon drifted from AA immersion to an increasingly psychological approach, leading to tension between the manager and the board (Harbaugh, 1995). This conflict eventually led to the resignation of Marty Mann from the board. Her resignation letter offers a window into the growing distinction between AA and treatment in the 1940s.

> *At Blythewood, a particular method of treatment, psychiatry, was used by one man, Dr. Tiebout, to help me get well. At the Farm, now, a particular method of treatment (the word is Ray's own: one might call it metaphysical psychology…) is being used by one man, Ray C_____, to help others get well. I repeat: I have nothing against either method of treatment. But they belong in one classification; and the Farm as it used to be, and A.A. as it is, belong in another....* **(**White, 1998, p. 174).

The boundary between treatment and AA again threatened to become blurred in the late 1940s and early 1950s with the development of the "Minnesota Model" of alcoholism treatment. This model incorporated AA principles and practices into treatment, hired AA members as alcoholism counselors and spawned a halfway house movement that also relied heavily on a Twelve Step philosophy. The 1950s mark the beginning of AA's profound and widespread influence on alcoholism treatment—an influence that grew as the Minnesota Model was replicated across the United States and indeed the world in the 1970s and 1980s. To avoid potential misunderstandings about the distinction between AA and professional alcoholism treatment, AA discouraged the use of names for institutions (e.g., "Twelve Step House") and roles (e.g., "AA Counselor" "Two-Hatter") that conveyed affiliation or sponsorship by AA. This experience also led AA's General Service Office to issue special guidelines for AA members who worked in the professional alcoholism field (Alcoholics Anonymous, ND).

As AA concepts and treatment concepts became increasingly blurred in the 1990s, there was growing concern within Alcoholics Anonymous about the effect treatment was having on the fellowship and even its program. (The percentage of people entering AA via referral from treatment increased from 19% in 1977 to 40% in 1989. Makela, et al, 1996). AA old-timers lamented the distortion of AA spirituality with what they perceived as the pop psychology of alcoholism treatment, complained that some AA meetings were turning into group therapy sessions filled with pained confessions and discussions of "codependency issues" and how to get in touch with one's "inner child," and expressed fears that the growth in treatment had weakened the service ethic within AA.

This infusion of treatment language and concepts into Alcoholics Anonymous prompted historian Ernest Kurtz (1999) to define "real A.A" as represented in the fellowship's own experience and literature. He suggested five criteria through which authentic AA meetings could be identified: 1) the use of a language of spirituality (as opposed to the vocabulary of therapy), 2) humor and appreciation of paradox, 3) the distinctive AA story style ("what we used to be like, what happened, what we are like now"), 4) respect for the Twelve Traditions, and 5) an experience of community (based on members' *need* to be there).

11. The NCEA Affair

In 1944, Mrs. Marty Mann, one of the first women to get sober in AA, developed a personal vision that would change America's perceptions of alcoholism and the alcoholic. To fulfill this vision, she created the National Committee for Education on Alcoholism (NCEA)—precursor to today's National Council on Alcoholism and Drug Dependence. Mann proposed five ideas as the centerpiece of her public education campaign:

> *1. Alcoholism is a disease.*
> *2. The alcoholic, therefore, is a sick person.*
> *3. The alcoholic can be helped.*
> *4. The alcoholic is worth helping.*
> *5. Alcoholism is our No. 4 public health problem, and our public responsibility* (Mann, 1944, p. 357)

Mann and NCEA went on to establish local branches that 1) conducted public education campaign on alcoholism, 2) encouraged local hospitals to admit alcoholics for acute detoxification, 3) established alcohol information centers, 4) established clinics for the diagnosis and treatment of alcoholism, and 5) created "rest centers" for the long-term care of alcoholics (Mann, 1947, p. 255).

Several things for a time blurred the boundary between AA and NCEA. First, Mann started NCEA with the blessings of AA's co-founders, broke her AA anonymity in her NCEA role (initially with the permission of Bill Wilson), and talked extensively about AA in her non-stop lectures around the country. Second, the names of Bill Wilson and Dr. Bob Smith appeared on the NCEA letterhead, suggesting an affiliation between AA and NCEA. This blurring of boundaries reached a point of crisis in 1946 when NCEA sent out a solicitation of funds on the letterhead bearing the Wilson and Smith names. The storm of protest from local AA members prompted the conclusion that "total non-affiliation was the only solution" to AA's relationship with other organizations (PIO, 1984, p. 320).

The NCEA affair confirmed three things. First, it established that AA is not an organization whose focus includes public education and public policy advocacy. AA's mission is not one of social change: it is not a temperance movement or a movement to change alcohol-related social policies and programs. Second, it confirmed the need for complete organizational autonomy and separation of AA from all other organizational entities. Finally, it affirmed the need for a set of principles that could guide AA's organizational life.

12. "Bill's Damned Traditions"

The rapid growth and considerable internal conflict experienced within local AA groups in the early 1940s set the stage for the development of AA's Twelve Traditions (Wally P., 1995; Pearson, 1985). Bill Wilson, through his travels to AA groups across the country and through his prolific correspondence, spent a growing amount of time offering guidance and the lessons being learned from local groups experience on the many points of contention. It was Earl T., one of the original Chicago members, who first suggested the need for a set of principles of self-governance for AA. That suggestion assumed greater weight when Bill Wilson read a 1945 AA Grapevine article on the rise and fall of the Washingtonians in the 1840s from many of the very issues that were then plaguing AA (Wilson, 1945). The resulting principles of self-governance--AA's Twelve Traditions--linked personal recovery to AA unity; acknowledged God as the ultimate authority in AA as expressed through group conscience, posited a model of servant leadership; established a single membership criteria ("a desire to stop drinking"), affirmed local group autonomy, committed AA to a singular purpose ("to carry its message to the alcoholics who still suffers"), established the principles of non-affiliation and financial self-support, eschewed professionalism and excessive organization, declared a position of silence on outside issues, confirmed a public relations policy based on attraction rather than promotion, and posited anonymity as the "spiritual

foundation" of all of the traditions ("principles before personalities") (TSTT, 1981).

The Twelve Traditions were first formulated and disseminated in 1946. Early reviews were lukewarm, with groups occasionally referring to them as "Bill's damned traditions." Some groups during this period invited Bill to speak if he would agree NOT to talk about the traditions. But support for the traditions grew as they came to be seen as a synthesis of AA's hard-earned experience. They were formally adopted at AA's first International Convention in 1950. AA's Twelve Traditions allowed the fellowship to chart a path that avoided the pitfalls of centralization of organizational power, charismatic leadership, money and property, professionalism, and organizational growth and decay that had plagued earlier recovery mutual aid efforts (White, 1998; Room, 1993; Borkman, 2006). Few organizations have a mission, vision or values statement as visibly influential on the daily life of the organization as the Twelve Traditions are within the life of AA. That alone is a rearkable feat. Even more remarkable has been AA's ability to avoid the evolution from a mutual help movement into a formal, hierarchical organization with centralized leadership and a paid class of service professionals (Katz, 1981).

AA's Twelve Traditions make it clear that AA is not in the business of alcoholism treatment and that its members must forever reject any effort to professionalize AA service work:

> *"That we must, at all costs, avoid the professionalization of A.A.; that simple Twelve Step work is never to be paid for; that A.A.'s going into alcohol therapy should never trade on their A.A. connection; that there is not, and can never be, any such thing as an "A.A. therapist"* (Wilson, 1983, p. 27).

The Traditions freed AA members to work in paid and volunteer roles in alcoholism treatment or in alcoholism-related political advocacy, but to do so only as individuals who did not bring the AA name into such endeavors.

AA's commitment to singleness of purpose and its non-affiliation stance protects the fellowship from co-optation and colonization. When individuals and other groups concerned about other problems asked if they could join AA, they were politely told that they were welcome to adapt the AA program to those problems, but that they could not join Alcoholics Anonymous unless they met its single criterion for admission. This policy led to the wide adaptation of the Twelve Steps to nearly every conceivable problem while protecting the AA process of mutual identification—one alcoholic talking with another alcoholic. Even family members of AA members were excluded from AA's closed meetings,

which led in 1951 to the adaptation of the AA program via the Al-Anon Family Groups.

A central test of all recovery mutual aid societies is whether that community of recovery can survive the passing of its charismatic leader(s) and first generation. Three events mark AA's mastery of this test: 1) the death of co-founder Dr. Robert Smith on November 16, 1950, 2) the replacement of the Alcoholic Foundation with the General Service Board of Alcoholics Anonymous in 1954 and the subsequent transfer of responsibility for AA service from the co-founders and old-timers to AA membership, and 3) the death of co-founder Bill Wilson on January 24, 1971. These events successfully tested the ability of AA to self-sustain itself without centralized, charismatic leadership. Thirty-five years later that test has been met. AA's policy of elected and rotating leadership continues. AA's unique organizational structure guided in great part by the Twelve Traditions has withstood the test of time.

Alcoholics Anonymous and Alcoholism Treatment: Separate and Distinct

Seen as a whole, the twelve defining moments summarized in this paper shaped the character of Alcoholics Anonymous as an organization in ways that clearly distinguish AA from the process of alcoholism treatment and the institutions that provide such treatment. The intent of this review is not to portray one as superior to the other, but to suggest that they are distinct entities whose respective value requires separation and boundary protection. Alfred Katz (1981) articulates this principle of separation and respect when he notes that formal human service organizations and mutual aid groups have distinct qualities that should remain separate and be mutually respected. Ernest Kurtz argues a similar position regarding AA and therapy, noting that both have value, but that "it abuses both to present either as the other" (Kurtz, 1999, p. 164).

AA chose a minimalist approach to organizational infrastructure, whereas alcoholism treatment institutions are formal organizations with often elaborate hierarchies and levels of professional status. There are no CEOs, CFOs, or Directors in Alcoholics Anonymous. Where treatment institutions are subject to considerable governmental oversight and all the accompanying regulatory requirements (e.g., service documentation), AA is accountable only to its membership who act through each group's Group Service Representatives. There are no audits, no site visits, no records on individual members, and no monthly service reports. Treatment institutions rely on external funding and are heavily influenced by the dictates of funding agencies; Alcoholics Anonymous is supported only by the contributions of its members and the sale of its literature.

Service relationships in alcoholism treatment are hierarchical (inequality of power), fiduciary (one party having legal obligation for the care of the other), and commercialized (one party is being paid to be there); service relationships in AA are non-hierarchical, reciprocal (mutuality of support) and non-commercialized (no member is paid for his or her support of another member). Clinical staff in alcoholism treatment programs are expected to be credentialed (educated, certified and licensed) by external authorities; status within AA comes solely from one's history, character and conduct within the AA community. Where the former focuses on the importance of professional assessment and diagnosis and professionally directed treatment planning, AA emphasizes self-diagnosis and following the steps that others have found successful. The emphasis on the knowledge and technique of the treatment professional and adherence to service protocol in alcoholism treatment is replaced in AA with an emphasis on what each AA member must do each day to sustain his or her recovery.

There are significant risks of potential harm resulting from alcoholism treatment, e.g., stigmatizing diagnoses; expensive and potentially prolonged sequestration; pressure for intimate self-disclosures; "therapeutic" confrontation; potential side-effects of medications, and significant consequences for failure to complete treatment and resuming alcohol and drug use. Such potential for harm is recognized and addressed, in part, through the mechanisms of informed consent, confidentiality procedures, clinical supervision and codes of professional conduct. The degree of personal invasiveness and harm in AA is minimized by the absence of treatment procedures, discouragement of taking others' "inventory", discouragement of cross-talk (feedback, advice, confrontation in response to another's disclosure) and through the protective mechanisms of AA's Twelve Traditions and group conscience.

The process of treatment and the process of AA are fundamentally different. Alcoholism treatment often involves getting into yourself by exploring painful aspects of one's personal history. In contrast, the AA experience is more one of getting out of oneself—connecting with resources and relationships beyond the self. Where alcoholism treatment often focuses on personal pain; Alcoholics Anonymous focuses on personal character, e.g., increasing capacity for honesty, forgiveness, gratitude and tolerance. Where alcoholism treatment often focuses on increasing self-esteem; AA focuses on ego-deflation, cultivation of humility and a shift in focus from "I" to "We."

AA is not a treatment for alcoholism, nor is AA a policy advocacy organization, a public information agency, or a religion. AA is a self-governed community of men and women who offer each other their "experience, strength and hope" toward the goals of 1) maintaining recovery from alcoholism, 2)

enhancing quality of life of those recovering from alcoholism, and 3) carrying a message of hope to the still suffering alcoholic. As stated in its own literature, AA is "not a social service organization," "not a cure," nor does it "prescribe treatment for alcoholism." "The sole purpose of AA is to help the alcoholic who wants to stop drinking" (Typical misconceptions about A.A., 1951).

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